Law and the Public's Health

This installment of *Law and the Public's Health* examines Medicaid's free-choice-of-provider guarantee in the context of access to family planning services.

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MEDICAID'S FREE-CHOICE-OF-PROVIDER PROTECTIONS IN A FAMILY PLANNING CONTEXT: *PLANNED PARENTHOOD FEDERATION OF INDIANA V. COMMISSIONER OF THE INDIANA STATE DEPARTMENT OF HEALTH*

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In May 2011, the state of Indiana enacted a law prohibiting state agencies from contracting with any entity that performs abortion. Its effect was to bar Medicaid participation by Planned Parenthood of Indiana (PPIN), an important provider of Medicaid-covered primary and preventive services for beneficiaries and low-income people. In June 2011, following a determination by the Centers for Medicare and Medicaid Services (CMS) that Indiana's law violated federal Medicaid requirements, a federal judge enjoined the state from implementing the law. This installment of *Law and the Public's Health* examines Medicaid's freedom-of-choice provision and assesses the implications of the federal court ruling for policy and practice.

OVERVIEW

On May 10, 2011, the Indiana legislature passed House Enrolled Act 1210 (HEA 1210), which included a provision preventing entities other than hospitals or ambulatory surgical centers that perform abortions from receiving any state funding for health services unrelated to abortion, including cancer screenings, Papanicolaou (Pap) tests, sexually transmitted disease (STD) testing, and family planning services.[1] On the same day, PPIN, a principal focus of the law, along with several individual plaintiffs, filed a lawsuit alleging that the Indiana law violated federal Medicaid law.[2] (The lawsuit also challenged that portion of Indiana's law debarring PPIN from participating in Title X of the Public Health Service Act, which provides grants to fund family planning services.)

As in nearly all other states, PPIN is a major source of primary health care for Medicaid beneficiaries and other low-income people in Indiana who need cancer screenings such as Pap tests, STD testing, and family planning services and supplies. In 2010, PPIN furnished preventive and family planning services and supplies to more than 9,300 Medicaid patients.[3] PPIN estimated Indiana's law would force the closure of 13 clinics, which served 33,577 patients in 2010.

As a condition of implementing its law, Indiana had to file a state plan amendment with CMS, which has the power to review and either allow or disallow changes to state Medicaid programs affecting eligibility, coverage, provider participation, payment, and state administration matters. Indiana's Medicaid state plan amendment 11-011 was filed on May 15, 2011, and included a prohibition on contracts between the state Medicaid agency and providers (other than hospitals and ambulatory surgery centers) that perform abortions or maintain or operate facilities where abortions are performed. If approved, the amendment would have barred payment to PPIN for Medicaid-covered services such as family planning, cancer screening, screening and treatment for STDs, and other reproductive health services, including, potentially, abortions that are covered under federal law in cases of rape, incest, or where the life of the mother is in danger (this restriction, known as the Hyde Amendment, has been added to every appropriations bill since 1976).[4] On June 1, 2011, CMS rejected Indiana's state plan amendment on the grounds that the debarment violated federal Medicaid law, specifically Medicaid's free-choice-of-provider requirement.[5]

On June 24, 2011, the federal district court in which the case (*Planned Parenthood of Indiana v. Commissioner of*

the Indiana State Department of Health) was filed enjoined implementation of the law and ordered payment of all covered claims by PPIN.[3] In so ruling, the judge gave deference to CMS's interpretation that Indiana's new law violates beneficiaries' federal right[6] to receive covered services from the qualified provider of their choice. The June injunction issued by the trial court is legally binding on the state until and unless its ruling is overturned on appeal.

MEDICAID'S FREE-CHOICE-OF-PROVIDER GUARANTEE AND SPECIFIC PROTECTIONS FOR ACCESS TO FAMILY PLANNING SERVICES

Based on the text and history behind Medicaid's freedom-of-choice provision, the federal district court's interpretation that the free-choice-of-provider provision bars the types of exclusionary practices attempted by Indiana is likely to be upheld on appeal.

The freedom-of-choice provision was added to Medicaid through an amendment in 1967. A central aim of Medicaid's 1965 enactment was to improve access to health care by the poor. Predecessor federal medical assistance programs, specifically Kerr-Mills, experienced insufficient provider participation and limited access to care.[7] Medicaid was intended to alleviate these shortcomings by broadening the scope of coverage to which the poor would be entitled.[8] A second program goal—aspirational only and not included as specific statutory text in 1965—was to allow patients the freedom to choose their care, rather than requiring that they use access points selected by state or county governments. This freedom to choose was viewed as particularly important because, from the beginning, Medicaid was designed also to supplement Medicare for the poor elderly, and free choice of medical provider was a cardinal tenet of that program. As such, lawmakers hoped that a comparable Medicaid free-choice goal would incentivize private physicians to treat low-income Medicare beneficiaries by assuring payment for uncovered deductibles and copayments as well as for treatments and services not covered by Medicare.

Although a free-choice-of-provider right was not included in the original Medicaid statute,[9] the ability to choose one's health-care provider was an express focus of the 1965 debate because of concerns on the part of some legislators and other stakeholders that federal health insurance would lead to socialized medicine.[10] In 1967, Medicaid was amended to codify this freedom-of-choice expectation[11] in the wake of evidence from Medicaid's first two years of existence that states had, in fact, acted to limit beneficiaries' access to health-care settings of states' choosing (as in Puerto Rico, which had limited Medicaid beneficiaries to government facilities)[12] or had restricted payments to providers in certain settings.[13] These practices were contrary to Medicaid's goal of expanding access to health-care providers[14,15] and inconsistent with Medicare.[16] Therefore, in response to states' restrictions on access (as well as a general outcry from providers), Congress adopted a Senate provision clarifying the free-choice-of-provider protection.[17]

Essentially unchanged in its central elements since first added to the law, the provision states the following:

> [A]ny individual eligible for medical assistance . . . may obtain such assistance from any institution, agency, community pharmacy, or person, qualified to perform the service or services required . . . who undertakes to provide him such services.[18]

When family planning services and supplies were added to Medicaid as a required benefit in 1972,[19] the free-choice-of-provider statute automatically applied to this new set of benefits. Furthermore, the Affordable Care Act[20] creates new eligibility options for states that seek to extend coverage for family planning (and family planning-related services) to populations who otherwise would not be eligible for Medicaid.[21]

Over the years, the free-choice-of-provider provision has undergone multiple revisions, as Congress has amended federal law to allow states to impose greater restrictions on choice of qualified providers in a managed care context. However, despite the fact that the current law allows states to restrict freedom of choice either as a state plan option[22] or through special federal free-choice waivers,[23] the right to freely choose among qualified participating family planning providers has been explicitly preserved. Thus, state Medicaid programs' managed care authority is tempered by specific statutory provisions that prevent states from eliminating or curbing free choice of family planning providers. Indeed, Congress's commitment to unfettered access to family planning services and supplies has been so strong that amendments in 2006 allowing states to curb Medicaid coverage for certain beneficiaries through the use of more narrow "benchmark benefit plans" still preserved the required coverage of family planning services and supplies, with no cost sharing and with unrestricted access to coverage and without regard to otherwise-applicable network restrictions.[24]

Some states, interest groups, and policy makers (including a group of Republican senators)[25] have argued that a separate provision of the Medicaid statute, added in 1987, allows states to restrict participation by qualified providers. This provision authorizes states "in addition to any other authority" to exclude

providers for "any reason for which the Secretary [of the U.S. Department of Health and Human Services (HHS)] could exclude the individual or entity from [Medicare] participation."[26] In the view of some parties, including the state of Indiana, this provision would give a state the authority to exclude a provider for any reason.[27] However, this argument overlooks the language and history of the provision. The language makes clear that a state's power to exclude tracks any basis for which the Secretary has the power to exclude. Under Medicare, the Secretary could not exclude a provider simply because the provider also furnishes lawful treatments not covered by Medicare. The provision added in 1987 was designed to clarify that states have the same power as the Secretary to exclude providers from their programs for reasons of fraud or abuse and to protect patients from incompetent providers.[28] It does not alter Medicaid's basic requirement that participation standards be reasonably related to a provider's ability to efficiently and effectively provide the covered treatment or procedure in question.[29] This principle is particularly true for family planning services and supplies, where Congress has shown special concern for access and has preserved free choice even in the case of individuals enrolled in managed care plans, who are otherwise limited to their provider networks for nonemergency care.

CMS emphasized the limited nature of this later provision in its rejection of Indiana's proposed state plan amendment, explaining that states can "impos[e] reasonable and objective qualification standards" for providers but that "[t]he purpose of the free choice provision is to allow [Medicaid] recipients the same opportunities to choose among available providers of covered health care and services as are normally offered to the general population."[30] For this reason, CMS has disapproved state plan amendments that have sought to impose restrictions on providers unrelated to their ability to provide or properly bill for services.[31] Indeed, CMS's policy is well-known; when the Indiana legislature was considering HEA 1210, the state's Legislative Service Agency noted in the Fiscal Impact Statement for the bill that "[f]ederal law permits states to define a qualified provider, but requires that this definition is related to a provider's ability to perform a service and not what services are provided."[32]

The history of this later provision further underscores that the amendment was not intended to expand state authority to exclude providers for any reason. The provision was enacted as part of the Medicare and Medicaid Patient and Program Protection Act of 1987 and its purpose was to protect beneficiaries from providers who lose their license in one state but continue to practice in another because the second state lacks the power to revoke a license based on another state's actions.[33] Under prior law, HHS could not exclude practitioners from Medicare and Medicaid programs in all states based on licensing board actions in one state; instead it could deny payment only for services rendered in a state where the practitioner had lost his license. HHS also lacked the authority to exclude individual providers or entities that had been convicted of crimes unrelated to the programs, such as fraud, financial abuse, neglect of patients, or unlawful distribution of a controlled substance. In addition to expanding HHS's exclusionary powers under Medicare, the 1987 law extended power to states to revoke Medicaid participation rights for the same reasons. It was not a grant of unlimited authority over provider participation.

CONCLUSION AND IMPLICATIONS

The Medicaid freedom-of-choice provision is intended to protect the right of beneficiaries to select the participating provider of their choice, regardless of state efforts to steer patients toward certain providers or to deny them access to qualified providers that satisfy all reasonable program requirements. The history of Medicaid's amendments demonstrates that states' authority to exclude providers is limited to cases of incompetence, fraud or abuse, or the limited circumstances of managed care. Moreover, even where states can limit free choice of provider, as in managed care, states must ensure that patients remain free to choose their provider for family planning services and supplies. Freedom of access to qualified providers goes hand in hand with Medicaid's primary goal of increasing access to health care, not impairing it.

Individual states cannot redefine "qualified provider" as a way to exclude certain providers, just as they cannot require Medicaid beneficiaries to use a hospital or pharmacy of the state's choosing. To allow otherwise would undermine Medicaid's central purpose of increasing access to health-care services. Laws such as Indiana's would circumvent federal minimum standards that protect Medicaid beneficiaries and reduce access to critical services for low-income women, such as family planning services and STD testing.

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